UF UNIVERSITY of FLORIDA

Please mail packet to:
Department of Psychiatry
Attn: Division of Psychology
4197 NW 86th Terrace
Gainesville, FL 32606

DEMOGRAPHIC INFORMATION

Name _____ Sex: **Male / Female**

Date of Birth _____ Age_____ Phone (home) _____ Phone (mobile) _____

May we leave a message stating we are calling from UF Health at these numbers? **YES / NO**

Available times for sessions (please list all possible):

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

MAIN CONCERNS

1. What problems are you most concerned about and would like help with?

_____

_____

2. How long have you been experiencing these problem(s)? _____

3. Have you had difficulties or problems like this before? **YES / NO**

If YES: When? _____ Did you seek treatment? **YES / NO**

What seemed to help? _____

4. Who referred you here? _____

CURRENT FAMILY

Marital Status: __Single __Married __Divorced __In a relationship

If applicable:

1. How long have you been with your current partner? _____
2. Are you currently living with your spouse/partner? **YES / NO**
4. Rate your satisfaction with your marriage/relationship on a scale of 1 to 7 (poor to excellent):

Poor 1 2 3 4 5 6 7 Excellent

5. Are you having any current problems in your marriage/relationship that you would like help with?

_____

6. Please list the names, ages and gender of any children you have:

Name	Age	Sex	Step/Biological	Location

FINANCIAL ASSESSMENT

1. What is your main source of income? _____

2. Do you currently have any financial problems? **YES / NO**

LEGAL ASSESSMENT

1. Have you ever been arrested? **YES / NO**

2. Do you have any current legal difficulties / issues? **YES / NO**

If YES: Please explain: _____

PSYCHOLOGICAL ASSESSMENT

1. Have you recently experienced or do you presently have any of the following?

Symptoms	**Yes**	**No**	Symptoms	**Yes**	**No**
Loss of Energy			Feeling Guilty		
Appetite Change			Upset by Problems at Home		
Difficulty Concentrating			Upset by Problems at Work		
Panic/Anxiety			Seeing Things Others Do Not See		
Depression			Hearing Things Others Do Not Hear		
Sleep Problems			Relationship Problems		
Loss of Interest in Activities			Often Trip or Fall When Walking		
Feeling Helpless/Hopeless			Dizziness / Vertigo		
Hurt or Tried to Kill Self in the Past			History of Loss of Consciousness		
History of Violent Behavior			History of Seizures / Epilepsy		
Low Self Esteem			Poor Impulse Control		
Upsetting, recurrent thoughts			Repetitive behaviors that you feel you have to do		

2. What are currently your main sources of stress? Please list from *most* stressful to *least* stressful:

_____

_____

_____

3. If you experienced significant trauma in the past, please BRIEFLY describe the incidents that bother you the most TODAY (specific details are not necessary, but a clear and brief description of the event is needed).

_____

_____

_____